WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

File Naming Example:

Record of Comm. Proceedings ... RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

Published Documents

- *Committee Hearings ... CH* (Public Hearing Announcements)
- **

- *Committee Reports ... CR*
- **

- *Executive Sessions ... ES*
- **

- *Record of Comm. Proceedings ... RCP*
- **

Information Collected For Or Against Proposal

- *Appointments ... Appt*
- **

- *Clearinghouse Rules ... CRule*

**

- *Hearing Records ... HR* (bills and resolutions)
- **05hr_sb0614_SC-AI_pt01**

- *Miscellaneous ... Misc*
- **

Sentry Insurance
1800 North Point Drive
Stevens Point, WI 54481
(608) 255-7115 Madison office
(608) 255-2178 fax

Misha Lee
Director of Government Relations

misha.lee@sentry.com

SENTRY INSURANCE

TO: Senate Committee on Agriculture and Insurance
Assembly Committee on Insurance

FROM: Misha Lee
Director of Government Relations

DATE: February 21, 2006

RE: **OPPOSITION to Senate Bill 614 and Assembly Bill 1039**

On behalf of Sentry Insurance, we urge you to **OPPOSE** Senate Bill 614 (SB 164) and Assembly Bill 1039 (AB 1039) that would impose new statutory requirements for insurers as it relates to chiropractic services.

Sentry strongly objects to the expansive, unnecessary and confusing nature of this legislation for the following reasons:

- Creditors already have rights available to them for collection of their bills. It is unclear why chiropractors should have higher priority or greater rights than other creditors.
- Wisconsin law recognizes comparative fault for third-party tort claims. Thus, a policy under which benefits are paid or payable often is reduced by the comparative fault of the claimant. Therefore, a claimant's assignment to a provider of any recovery they have from insurance is not automatic in all cases [*see Section 3 of the bill*].
- In a third-party situation, in particular, it is not established prior to a court ruling or verdict that an insurer (who only is liable for the amount of liability attributed to their insured up to the policy limits) is liable for any medical or other damages.
- Despite whether or not the claimant is compensated for their injury through insurance proceeds, they remain responsible for the fair value of their treatment. The claimant does not owe for over treatment. Disputes over what is payable to one payee will artificially delay negotiation of the claim settlement to the detriment of the injured party [*see Section 7 of the bill*].
- The requirement of including providers on checks will make it extremely difficult to settle claims, clogging state courts with litigation that under current laws would otherwise be settled. This provision in the bill only serves to protect and benefit one special interest group [*see Section 3 of the bill*].

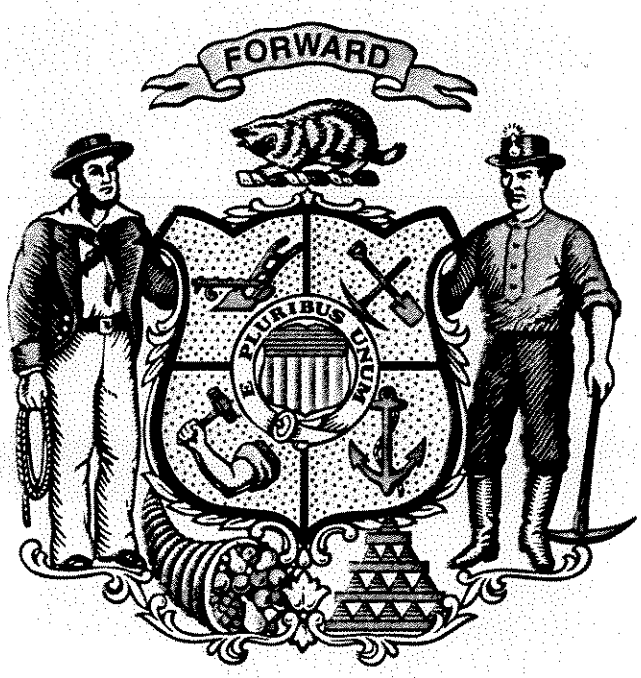
- In Workers' Compensation situations there are caps set for chiropractic care which under the WC Agreed Upon Bill will be part of the new WC treatment guidelines. This may be an attempt by one special interest group to circumvent those treatment guidelines. Any changes to Wisconsin's Workers' Compensation system should be carefully scrutinized by the Workers' Compensation Advisory Council (WCAC) [*see Senate Bill 474*].

- The legislation artificially reduces the pool of chiropractors available to provide independent evaluation of claims [*see Section 8 of the bill*].

- Insurance contracts are between two parties, the insurer and their insured. This legislation ignores the terms of the contract. If the contract requires the insurer to pay the insured and the insured does not give the insurer permission to pay a provider, this could place the insurer in a precarious position regardless of what they do.

Wisconsin's current system regulating how insurers work with chiropractors and other medical providers is a fair system that we believe works efficiently and in the interests of Wisconsin citizens. We respectfully urge you to **OPPOSE** Senate Bill 614 and Assembly Bill 1039.

Thank you for your consideration.


FORWARD
E PLURIBUS UNUM

Dean
HEALTH INSURANCE

Date: February 22, 2006

To: Members, Assembly Committee on Insurance
Members, Senate Committee on Agriculture and Insurance

From: Mr. Robert Palmer, President and CEO
Dean Health Plan

Re: Please OPPOSE Assembly Bill 1039/Senate Bill 614

Assembly Bill 1039 and Senate Bill 614 make various changes impacting the relationship between patients, chiropractors and insurers. This is a very broad proposal with significant implications. I urge you to oppose this legislation for the following simple reasons: it would lead to higher health care costs, it assesses a new tax on insurers, it reduces employer and plan flexibility and it needlessly increases the bureaucracy in the health care system.

Below are summaries of key provisions and reasons why such provisions are problematic:

1) *Require insurers to "give clear explanations when they deny care*". This is already done, and it is unclear how the proposed language changes achieve the stated intent. Additionally, Wisconsin, through the work of Senator Roessler, Representative Underheim and others, already provides extensive patient rights if coverage is denied. Wisconsin patients have various appeals procedures as well as independent external review. The proposed changes do not improve the current system.

2) *Require insurers to pay chiropractors directly when requested by the patient.* Chiropractors within a health plan are already paid directly just like most providers. Moreover, chiropractors (and providers) within a health plan are prohibited from holding the patient responsible for services covered under the patient's health plan (please see current s. 609.91). At Dean Health Plan, we typically pay the chiropractor directly even if they are NOT a network chiropractor.

However, a previous version of this legislation and the "plain language" explanation of that version indicate this provision is directed at a particular insurer. This makes the proposal even less constructive, as it unnecessarily interferes in the contractual relationship between patients, chiropractors and insurers apparently to resolve a business disagreement with one particular insurer.

3) *Require that copays for chiropractors be the same as physicians.* This provision is not currently an issue at Dean Health Plan because our copays are the same. However, copays can also be determined by the employer or purchaser group, who often use the copay as a cost-control mechanism. This is becoming more common as Health Savings Accounts (HSAs) and other consumer-driven plans continue to grow, with the strong support of this Legislature. Consequently, this provision will reduce plan flexibility for the patient, payer (employer) and insurer, thus contradicting the growing movement towards HSAs and other consumer driven plans and removing a tool for cost containment.

Dean Health Insurance, Inc.
P.O. Box 56099 • Madison, WI 53705 • (608) 836.1400 • (800) 356.7344 • fax (608) 827.4212 • Dean Health Plan, Inc.
1277 Deming Way • Madison, WI 53717
Medicare questions (608) 827.4372 • (888) 422.3326 • TTY (877) 733.6456
www.deancare.com

4) *Improve the standards for independent medical examiners (IMEs).* We agree such independent medical examiners should be well-qualified and believe that board certified, practicing clinicians who satisfy our rigorous credentialing process meet and exceed such standards. This is also the recommendation of our nationally respected accrediting body, the National Committee for Quality Assurance. There is no evidence the changes in qualifications recommended in this legislation achieve a new and improved standard. As discussed in point 1 on the previous page, the extensive right of patients in Wisconsin to appeal coverage denials requires us to have a thorough and professional IME process. Again, this provision offers no improvement over current law.

Additionally, these provisions require the insurer to provide "*the name of the evaluating chiropractor or, if a peer review committee conducted the independent evaluation, the names of all of the chiropractors on the peer review committee.*" AB 993, related to confidentiality of health care review records, provides for peer review analyses to be confidential and protects participants in such evaluations from legal action. This provision of AB 1039/SB 614 completely contradicts this sound policy.

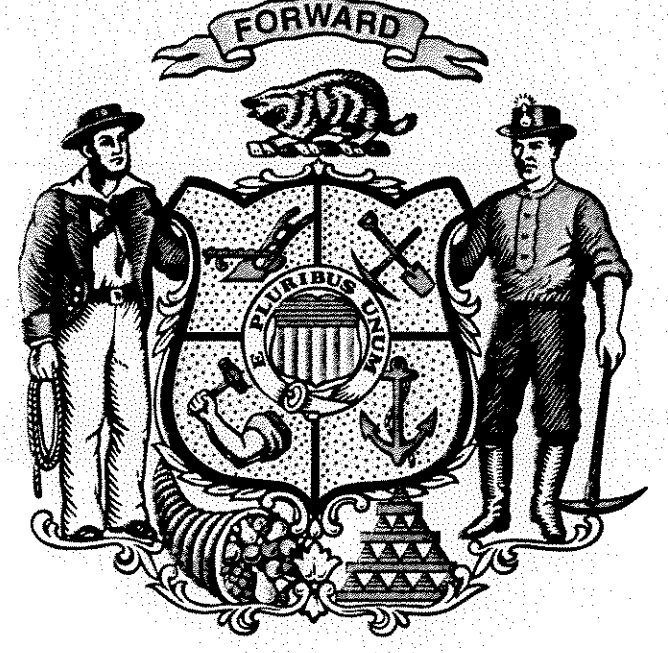
These provisions also require insurers to submit information regarding the results of all IMEs (approvals, denials and costs of denied coverage), as well as the participating chiropractor. Finally, these provisions create a new tax on insurers to fund this new administrative burden. Requiring insurers to complete and submit these new reports, as well as pay for the reporting system, will only increase needless bureaucracy in health care and increase costs for everyone.

5) "*Requires an insurer who changes the current procedural terminology code that the health care provider put on the health insurance claim form to include on the explanation of benefits form the reason for the change and to cite the source for the change.*"

The CPT code is used to help determine payment to providers consistent with contractual terms. This provision is unnecessary for two reasons: providers and insurers typically negotiate such matters in their contracts, and federal HIPAA laws already regulate this process. Moreover, there are literally thousands of such codes. Requiring explanations for change and citing the source for change will not provide usable information for the patient and is simply not practical. Also, like the previous section, this will needlessly require further bureaucracy, thus increasing costs.

As you can see, the entire proposal is fundamentally flawed: it reduces employer and plan flexibility (at a time when such flexibility is needed to meet the growing demand for consumer driven plans), assesses a new tax on insurers, increases costs and requires additional bureaucracy. All of this contradicts efforts of this Legislature, employers and insurers to control costs and provide health care options for patients and payers. Therefore, we urge you to oppose this legislation.

Thank you for your consideration. Please contact me if you have questions or would like additional information. I may be reached at (608) 827-4206 or via email at: robert.palmer@deancare.com. You may also contact Michael Heifetz, VP for Governmental Affairs, at (608) 250-1225 or at: michael.heifetz@deancare.com.


FORWARD
PLURIBUS UNUM

WISCONSIN ASSOCIATION OF HEALTH UNDERWRITERS

Wisconsin's Benefit Specialists

Senate and Assembly

Joint Public Hearing

Committee on Agriculture and Insurance

Assembly Bill 1039 & Senate Bill 614

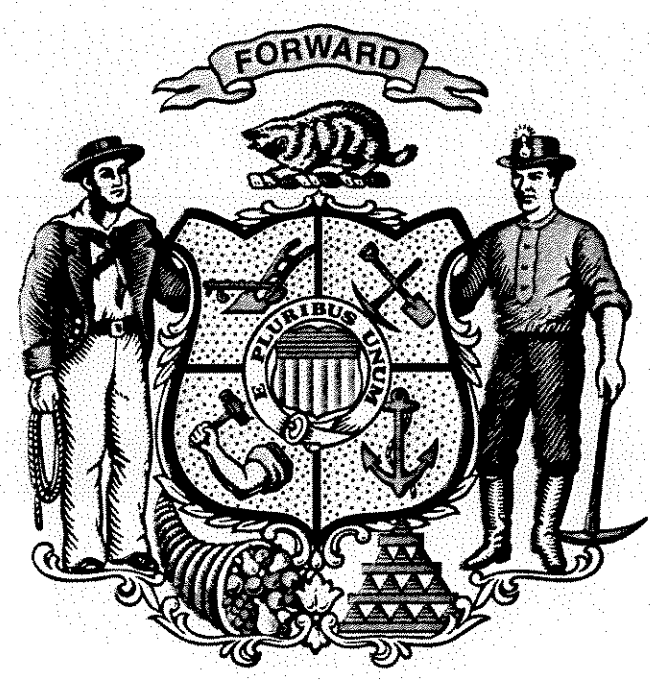
February 22, 2006

We would like to thank the members of the Committees for allowing us to provide written comments on the above referenced legislation. The members of the Wisconsin Association of Health Underwriters (WAHU) and National Association of Health Underwriters (NAHU) are comprised of insurance professionals involved in the sale and service of health benefits, long-term care benefits, and other related products, serving the insurance needs of over 100 million Americans. We have almost 18,000 members around the country and nearly 600 members here in Wisconsin. Our membership is primarily made up of insurance agents that work directly for and with the consumers of health care. Since our number one concern is our customers, we consider ourselves to be consumer advocates and look at how any legislation or regulation will affect these customers.

WAHU strongly opposes AB 1039 and SB 614. For too long, the legislature has passed insurance mandates removing choice from the marketplace and increasing both utilization and costs. This legislation would deter from the ability for health plans to curb abuses in utilization patterns, which will only increase health insurance premiums and exacerbate our current health care cost crisis. For some time, WAHU has been urging the legislature to consider legislation that would actually give back control to consumers relative to the types of plans they wish to purchase. This legislation is known as Benefit Flexibility or Mandatory Offering. It would require insurers to offer all of the existing mandates, but would not require consumers to purchase those plans if they did not want them.

We urge you to support Mandatory Offering and to reject proposals that expand our current state mandates and increase health insurance premiums, like AB 1039 and SB 614 would do.

Wisconsin Association of Health Underwriters
608-268-0200
www.eWAHU.org
LegComm@eWAHU.org


FORWARD
E PLURIBUS UNUM

P.O. Box 2078
Madison, Wisconsin
53701-2078
www.pplusic.com

Physicians Plus
INSURANCE CORPORATION

(608) 282-8900
(800) 545-5015

TESTIMONY IN OPPOSITION TO ASSEMBLY BILL 1039/ASSEMBLY BILL 614
Joint Hearing of the Assembly and Senate Insurance Committees
February 22, 2006

Thank you for the opportunity to present testimony on Assembly Bill 1039 and Senate Bill 614 relating to various processes involving chiropractic care. I am Kathryne McGowan, Vice President of Marketing & Sales for Physicians Plus Insurance Corporation.

Generally, the health plan industry believes the proposed legislation establishes a new set of **additional requirements** for a subset of providers and **will increase health insurance costs at the expense of consumers**. I'd like to share our perspective on a few of the bill's provisions as examples of our concern.

- Settlement checks – There are already laws and regulations governing payment in subrogation cases—cases where a party other than the health plan, such as an auto carrier, is responsible for payment of medical care provided to the member of a health plan. Under subrogation law, HMOs feel legally obligated to provide the services and pay the providers according to the provider contracts in place. The health plans then seek reimbursement from the liable party and may end up with some payment—though typically not full payment—for the costs incurred in providing coverage. Most important, the patient is currently held harmless—they are protected from providers who might otherwise go after them for payment.

  AB 1039 and SB 614 appear to take chiropractors out of this established process that all other providers follow and establish a separate, unique mechanism for payment of chiropractic services. The result could leave health plan patients vulnerable to additional billing.

- Copayments and coinsurance for chiropractic services – HMOs already treat chiropractors the same as they treat physicians or osteopaths. Assembly Bill 1039 appears to be addressing a problem that doesn't exist.

- Explanation of insurer coverage decisions – Currently, state and federal law and standards established by the National Committee for Quality Assurance require insurers to provide an explanation or rationale for any denial of coverage. The change advocated in AB 1039 and SB 614 is unnecessary. Further, the provision requiring a "clinical rationale" for the decision may be inappropriate, since some denials are based on benefit limitations and not clinical decisions.

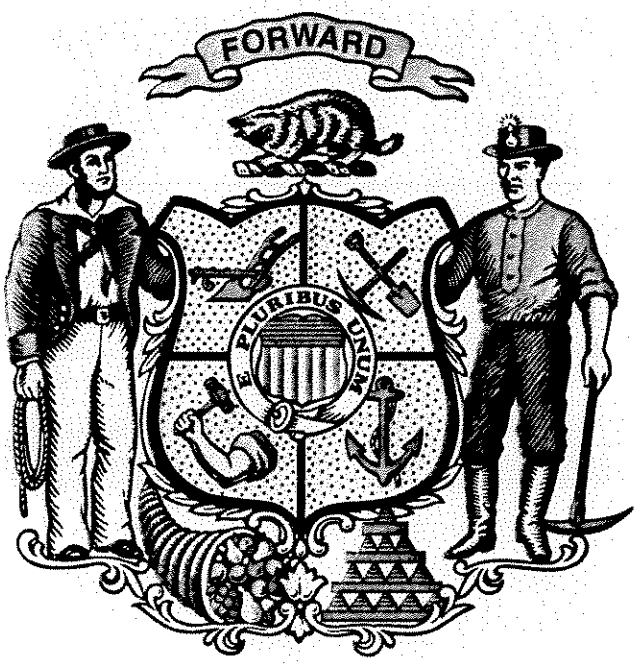
  Independent evaluation process – Current law already provides for a separate and distinct independent evaluation process for chiropractic coverage in addition to

incorporating chiropractic into the independent external review requirements applicable to all health insurance coverage decisions. We believe this is duplicative and unnecessarily cost-additive.

Instead of creating a new, additional and unique set of procedures for insurers to follow in chiropractic reviews, the Legislature should treat chiropractors the same as other providers and repeal 632.875, the special, duplicative independent review process for chiropractic care.

While the proponents of AB 1039 and SB 614 may speak of being treated fairly, this is another example of special treatment for chiropractic care. Further, the additional bureaucracy advocated in the new modifications to 632.875 creates new costs for the insurer and the insured, with no apparent benefit for the consumer.

Chiropractic services are an important part of the health benefit packages provided by health plans today. None of the provisions in AB 1039 and SB 614 will improve those benefits or add greater value for health plan members. On the contrary, AB 1039 and SB 614 will only add new bureaucratic processes that will serve only chiropractors at the expense of consumers and the declining commercial insurance market.


FORWARD
E PLURIBUS UNUM

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Senate Committee on Agriculture and Insurance
Senator Dan Kapanke, Chair
Members, Assembly Committee on Insurance
Representative Ann Nischke, Chair

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations
Jeremy Levin – Government Relations Specialist

DATE: February 22, 2006

RE: **Opposition** to Senate Bill 614 and Assembly Bill 1039 – Chiropractic Coverage and Payments

On behalf of nearly 11,000 members statewide, thank you for this opportunity to provide written testimony opposing Senate Bill 614 and Assembly Bill 1039, specifically due to potential negative ramifications related to mandates on the amount of co-payments for chiropractic services.

The bills would prohibit insurers from establishing higher co-payments or coinsurance requirements for chiropractor services than physician or osteopath services. While on its face this may seem to be a simple cost-saving measure, the potential effects of the prohibition give rise to two specific warnings: 1) patients may more often choose chiropractic care rather than physician care, including for initial evaluations; and 2) the mandate could actually increase overall costs to the health insurer via an increased share of costs exacerbated by a probable increase in the number of visits a patient would make to the chiropractor. These increased employer health care costs would likely pass through to employees.

Increased Chiropractic Utilization Could Mean Fewer Physician Evaluations

While this may seem a gratuitous criticism designed to "protect" physician business, news from a state where such a prohibition recently passed may shine greater light on the possible impetus for the proposal. According to the article "Landmark Insurance Legislation in North Carolina" in the October 10, 2005 issue of *Dynamic Chiropractor* (see attached), North Carolina introduced a similar requirement in the state's latest budget appropriations bill, which was signed into law. This made North Carolina the first state in the country to have legislation in place regarding co-pay equality for chiropractors. In the article "Chiropractors Expect More Business from Cut on Co-Pay," (August 26, 2005 print edition of the *Business Journal of the Greater Triad Area*-see attached), one chiropractor estimated that this change in the law could help him increase his business by 25 percent.

When utilization increases for specialty care like chiropractic, it stands to reason other care is sacrificed. The prohibition could therefore result in people seeking point-of-entry medical services from a chiropractor instead of from a physician. Physicians are trained to evaluate the overall head-to-toe health of the patient, with no limits on the scope of practice. Chiropractors, conversely, have a much more limited scope. A primary care physician is more extensively educated and trained to make a more comprehensive diagnosis on the patient's condition, and is therefore likely to be the initial contact most beneficial to the patient.

330 East Lakeside Street • PO Box 1109 • Madison, WI 53701-1109 • wisconsinmedicalsociety.org • Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

Prohibition Could Mean Increased Health Care Costs to Employers, Employees

Equal co-payments could also potentially increase insurance costs, as lowering of certain co-payments means the insurer covers a greater share of that service's cost. This leads to an overall increase in care insurers cover; the increased cost passes on to employers providing health coverage , who then likely pass part or all of that extra burden on to the employee.

To summarize, SB 614 and AB 1039 are troublesome in that they prohibit insurers from establishing higher co-payments or coinsurance requirements for chiropractor services than physician or osteopath services without addressing potential patient safety concerns. The prohibition could also increase overall costs for health insurers, meaning greater pressures on employers who provide health coverage to their employees.

Thank you for your time and consideration. Please contact Mark Grapentine (markg@wismed.org) or Jeremy Levin (jeremyl@wismed.org) at 608-442-3800 for further information.

ChiroWeb .com

Dynamic Chiropractic
October 10, 2005, Volume 23, Issue 21

Landmark Insurance Legislation in North Carolina

General Assembly Mandates Equal Co-Pays for Office Visits to DCs, MDs

Chiropractors in North Carolina - and for that matter, most of the general public - can be excused if they choose not to read all of the text contained in SB 622, the state's latest budget appropriations bill. At more than 189,000 words, it was one of the longest documents to be approved by the state's General Assembly in this year's legislative session.

Look closely, however, at one particular section of the bill, and you'll find some significant language relative to the chiropractic profession. Nestled between sections on funding for replaced equipment and planning for information collection is a provision requiring insurance companies to charge the same co-payment fee for chiropractic treatment as for visits to primary care medical doctors.

Previously, chiropractors in North Carolina had been classified by insurance companies as specialists, which increased the average co-payment for patients seeking their services above co-payments for primary care physicians, often by a factor of two or more. According to an article in *The Business Journal of the Greater Triad Area*, co-pays for primary care medical doctors in North Carolina average between $10 and $20, while co-pays for specialists could range as high as $40 or $50.

The new provision revises Section 58-50-30(a3) of the North Carolina General Statutes by adding the following language (excerpted as follows):

"An insurer shall not impose as a limitation on treatment or level of coverage a co-payment amount charged to the insured for chiropractic services that is higher than the co-payment amount charged to the insured for the services of a duly licensed primary care physician for the same medically necessary treatment or condition."

According to Tom Schoenvogel, executive director of the North Carolina Chiropractic Association, the provision mandating equal co-payment amounts for chiropractors and medical doctors is the first of its kind in the U.S.

"North Carolina is the first state in the country to have legislation in place regarding co-pay equality," said Schoenvogel. "It is our hope that this will set a precedent for other states to follow in securing co-pay equality between primary care physicians and chiropractors. Insurance carriers understand the importance of chiropractic in reducing the need for surgery and medications, making our efforts possible in North Carolina."

The new requirement also has the potential to save chiropractic patients hundreds of dollars in co-payments. *The Business Journal* article cited an example of a patient who visited a chiropractor a dozen times in a one-month period. With a co-pay of $50 per office visit, that patient would have to pay $600 out of pocket for care. With the new provision in place, lowering the co-pay to $20 would reduce out-of-pocket costs to $240, a 60 percent savings. The reduction in co-payments could also make chiropractic care more affordable for some patients, especially those living on fixed incomes.

When first approved by the General Assembly, the co-pay change was made retroactive to July 1, 2005. However, a follow-up bill approved in mid-August rolled the date back to March 1, 2005.

Resources

- Senate Bill 622/Session Law 2005-276. Approved Aug. 13, 2005. Available online at **www.ncga.state.nc.us**.
- Tosczak M. Chiropractors expect more business from cut on co-pay. *The Business Journal of the Greater Triad Area*, Aug. 26, 2005.
- E-mail from Thomas Schoenvogel, North Carolina Chiropractic Association, to *Dynamic Chiropractic*, Sept. 1, 2005.

Written by **Michael Devitt**, *senior associate editor of MPAmedia. Michael can be contacted at (714) 230-3181 or* **MDevitt@MPAmedia.com**.

The Business Journal of the Greater Triad Area - August 29, 2005
http://triad.bizjournals.com/triad/stories/2005/08/29/story5.html

THE BUSINESS JOURNAL
SERVING THE GREATER TRIAD AREA
From the August 26, 2005 print edition

Chiropractors expect more business from cut on co-pay

Mark Tosczak
The Business Journal Serving the Greater Triad Area

Triad chiropractors expect to see more patients more often thanks to a measure the General Assembly has approved that will lower insurance co-pays for chiropractic treatment.

The provision, passed as part of the state budget, requires insurance companies to charge the same co-pay amounts for chiropractic treatment that they do for visits to primary care medical doctors.

Previously, insurers treated chiropractors the same as specialists, which meant that patients' co-pays were higher. Co-pays for primary care medical doctors are typically in the $10 to $20 per visit range, while co-pays for specialists are sometimes as high as $40 or $50.

"It's going to benefit me, but it's going to really benefit my patients," said Dr. Joe Minder, a Burlington chiropractor. The change, he said, "could help me increase my business by 25 percent."

In a typical week, Minder, a solo practitioner, sees about 160 patients, he said.

The co-pay issue is especially important to chiropractors, because they typically treat patients over the course of several visits. Each visit requires a separate co-pay, so a reduction in the co-pay amount can make chiropractic treatment a lot cheaper for patients.

"It's a big struggle for some people to fit that into their budget," said Dr. Larry W. Grosman, a Greensboro chiropractor. "I think sometimes they made choices not to get care (because of the co-pays)."

Though the number of treatment sessions a patient requires can vary widely, Grosman said it wouldn't be unusual for a patient with acute pain to come in two or three times a week for the first month of treatments.

With a $50 co-pay, a dozen visits in the first month of intensive treatment could cost patients $600 out of pocket. A $20 co-pay would reduce that to $240 -- a 60 percent savings.

Typically, Grosman said, as problems are treated and patients improve, they need fewer visits.

Insurers, however, have been less enthusiastic about the change.

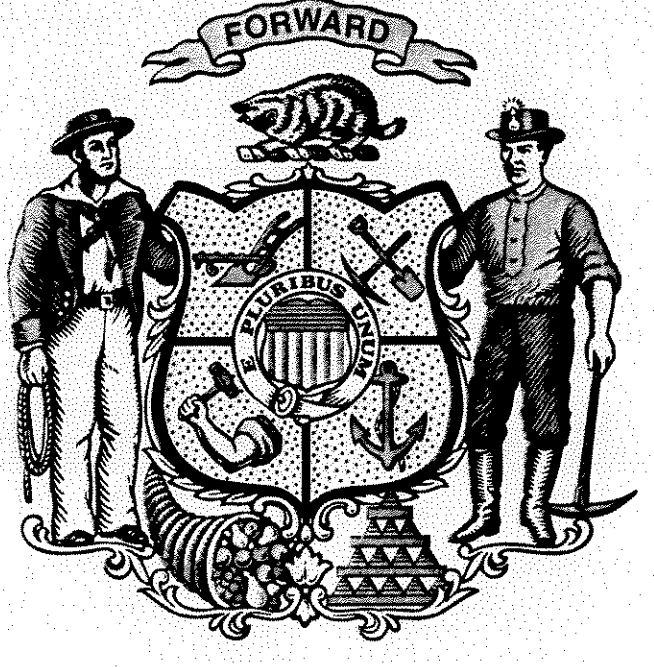
Blue Cross and Blue Shield of North Carolina, the state's biggest health insurer, hasn't yet figured out how much it will cost to make the change. The new co-pay will require changes in the company's computer systems, as well as to member ID cards and other materials.

The company also believes that primary care doctors, such as family medicine physicians or internists, are often the best first stop for any patient, said Mark Stinneford, a company spokesman.

Marlowe Foster, president of the N.C. Association of Health Plans, a trade group for insurers, said insurance companies don't know how much the co-pay change may increase health care costs. But the group thinks there will be increased administrative costs associated with the change as well as the possibility that people will use more chiropractic services.

When first approved by the General Assembly as part of the budget, the co-pay change was made retroactive to July 1. However, a follow-up bill approved by the Legislature in the wee hours of Wednesday morning rolled the date back to March 1.

Reach Mark Tosczak at (336) 370-2909 or mtosczak@bizjournals.com.


FORWARD
PLURIBUS UNUM

Keeping Wisconsin Families Safe
www.watl.org

EXECUTIVE DIRECTOR
Jane E. Garrott
44 E. Mifflin Street, Suite 103
Madison, Wisconsin 53703-2897
Telephone: 608/257-5741
Fax: 608/255-9285
Email: exec@watl.org

Testimony of Paul E. Sicula
on behalf of the
Wisconsin Academy of Trial Lawyers
before the
Assembly Insurance Committee
Representative Ann Nischke, Chair
And
Senate Agricultural and Insurance Committee
Senator Dan Kapanke, Chair
2005 Assembly Bill 1039/ 2005 Senate Bill 614
February 22, 2006

Good morning, Representative Nischke, Senator Kapanke and Committee members. My name is Paul E. Sicula, the legislative representative of the Wisconsin Academy of Trial Lawyers (WATL). On behalf of WATL, I thank you for the opportunity to appear today to testify against AB 1039 and SB 614.

WATL, established as a voluntary trial bar, is a non-profit corporation with approximately 1,000 members located throughout the state. The objectives and goals of WATL are the preservation of the civil jury trial system, the improvement of the administration of justice, the provision of facts and information for legislative action, and the training of lawyers in all fields and phases of advocacy.

AB 1039 and SB 614 specifies if an injured person is attempting to settle a personal injury claim with an insurance company, a settlement check must be made payable to three people, the injured party making the claim, the attorney representing the injured party and "any person who provided services to the injured party on account of the injury to which the claim relates and the services are covered under the policy," providing there is a validly executed assignment of benefits or payment form.

This would mean, rather than the general negotiations between injured parties and insurers, a new third party will now be sitting at the table asking for part of the settlement. This can only add more difficulty to already difficult negotiations.

Generally, the purpose of compensating a person for injuries suffered in an accident is to place that person in the same position he or she were in before the accident, in other words, the injured party should be made whole. One important factor is whether the injured party was also negligent in causing the accident. In Wisconsin, a person cannot recover if his or her negligence was more than the other party's. Any contributory negligence on the part of the injured person can decrease the amount the other party has to pay. For example, if the injured party was 20% at fault, he or she could only recover 80% of the value of the claim. So, if the value of the claim was $100,000, the injured party could only recover $80,000. This bill makes no provision for contributory negligence. The person providing the service is guaranteed payment out of the money received even if all the money is not recovered in the lawsuit.

Nor is there any provision for inadequate insurance. Using the same example as above, except assume there was only $50,000 in insurance coverage. Should the assignment take priority over all other bills, including payment to the injured party? This is why under Wisconsin law, a hearing can be held to review all the bills and judge determines which parties should receive the proceeds. The assignment procedure in this legislation goes around the current process and the health care provider with an assignment jumps ahead in the line to get paid first.

Neither is there a requirement that the service provider show that the treatment rendered was "reasonable and necessary." Too many times our members have seen situations where a health care provider has claimed that treatment is "accident-related," but both sides acknowledge this would be difficult to prove in a court of law. Unless there is some procedure set up where the assignment only applies to accident-related treatment, it could become a real problem for the injured party if the health care provider is demanding an assignment for unrelated care and there is no protection given the injured party. In addition, a health care provider should not have an absolute right to payment for care that is determined to be excessive, unreasonable or unnecessary.

Let me provide an example: Person A is involved in an automobile accident, where there are serious liability issues regarding fault. Person A had numerous pre-existing back problems and had received extensive treatment prior to the accident. In the accident, A aggravates the back problem, but also sustains an injury to her right arm. She

goes to the emergency room and has X-rays taken. She follows up with chiropractic care for her back. She receives physical therapy for her arm and while there receives therapy on her back as well. A obtains prescriptions from the pharmacy for pain relating both to her arm and back. A is also off three months as a result of the accident.

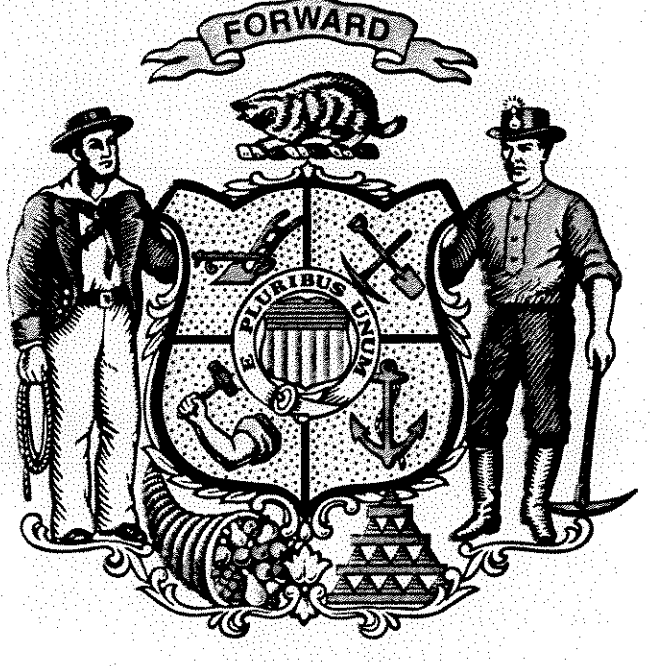
A incurs the following charges:

1. Hospital charges	$5,000.00
2. Orthopedic surgeon	$5,000.00
3. Chiropractor	$5,000.00
4. Physical Therapist	$5,000.00
5. Pharmacy	$2,000.00
6. Emergency Room	$2,000.00
7. Radiologists	$1,000.00
8. Lost wages	$8,000.00
Total	$33,000.00

The insurance company is claiming that the chiropractic care is related to a pre-existing injury. In addition, due to the liability concerns, the insurance company offers to settle the case for $20,000. What if the chiropractor, therapist and pharmacist have the patient sign the assignment of benefits form, does the settlement check have to include all these names? Do only these providers share in the recovery? Who gets paid first? Is it prioritized by date of filing? When the bills were incurred?

This whole process will make settlement of accident claims more difficult and expensive and may utilize settlement funds which would have gone to the victim or other health care providers and creditors.

We urge legislators to oppose this legislation. Thank you.


FORWARD
E PLURIBUS UNUM

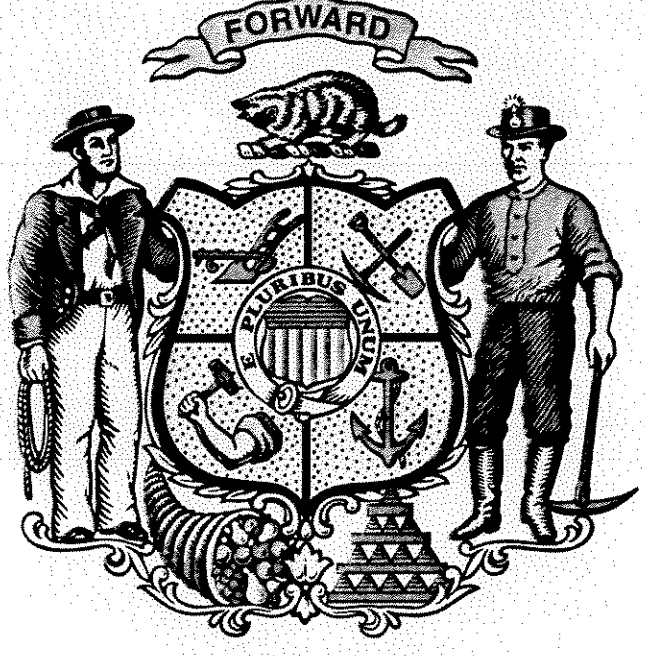
DEAR SENATOR KAPANKE,

MY NAME IS Mary K. Stuckey.
I am a constituent of yours and am also a chiropractic patient. I'm writing to ask Senator Kapanke to please support the chiropractic bill SB 614 and to schedule a committee vote as soon as possible. This bill is very important to us and we really appreciate your help.

THANK YOU,

Name Mary K. Stuckey

Address 38158 Stuckey Rd
Prairie du Chien, WI 53821


FORWARD
E PLURIBUS UNUM

WCA | **Wisconsin Chiropractic Association**
521 E. Washington Avenue
Madison, WI 53703
Tel. (608) 256-7023 • Fax (608) 256-7123

Insurance Equality Provisions

632.87(3)(A) No policy, plan or contract may exclude coverage for diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, if the policy, plan or contract covers diagnosis and treatment of the condition or complaint by a licensed physician or osteopath, even if different nomenclature is used to describe the condition or complaint. Examination by or referral from a physician shall not be a condition precedent for receipt of chiropractic care under this paragraph. This paragraph does not:

1. Prohibit the application of deductibles or coinsurance provisions to chiropractic and physician charges on an equal basis.

2. Prohibit the application of cost containment or quality assurance measures to chiropractic services in a manner that is consistent with cost containment or quality assurance measures generally applicable to physician services and that is consistent with this section.

(b) No insurer under a policy, plan or contract covering diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, may do any of the following

1. Restrict or terminate coverage for the treatment of a condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor.

2. Refuse to provide coverage to an individual because that individual has been treated by a chiropractor.

3. Establish underwriting standards that are more restrictive for chiropractic care than for care provided by other health care providers.

4. Exclude or restrict health care coverage of a health condition solely because the condition may be treated by a chiropractor.